# Improvements through Partnerships

**A Summary of the Mental Health & Mental Retardation/Developmentally Disabled Service System Plan for Improvements**
**November, 2001**

***This proposal is interactive and interdependent. This proposal is absolutely dependent upon a commitment by the state to provide adequate funding and must be adopted as a complete package.***

**Introduction:** Following the work of the Central Point of Coordination (CPC) Restructuring Task Force, CPC Administrators have been meeting to discuss and plan how best to serve the people of Iowa. Recommended enhancements to the current state/county financed, county operated system, have been motivated by many factors.

- **Leadership** – the Governor and DHS administrator have proposed major system changes
- **Legislative Initiatives** – adult decategorization pilot projects and legislative discussions on restructuring initiatives, and
- **Mental Health Reform a Major ISAC Legislative Priority**

Based upon the recommendations of the CPC Restructuring Task Force, CPC Administrators and stakeholders have reached consensus on seven objectives for system improvement. These suggestions call for a continued partnership with fundamental changes for both the state Department of Human Services (DHS) and for all counties administering mental health and mental retardation / developmental disability services. The goals of the recommended changes are to:

- **Enhance the quality of life and self-sufficiency of consumers;**
- **Improve the quality and effectiveness of services for consumers;**
- **Enhance the participation of families and consumers at all levels of the service system;**
- **Maintain and enhance the best elements of a locally administered system**
- **Specify the state's/counties' responsibility to fund equitable access for eligible consumers; and**
- **Redefine state-county roles to enhance accountability & effective management.**

## *What do we need to do !*

1. **Standardize clinical and financial eligibility for defined core mental health and mental retardation/developmental disability services on a statewide basis**: Currently, counties have different financial, clinical and service eligibility requirements for access to services. In addition to general clinical and financial eligibility standards, consistent statewide level of care and service access criteria and protocols will be developed to provide fair, consistent, equitable access. Input from stakeholders would shape the development of standards. Crisis response, disaster response outreach, public education and community consultation would be recognized as necessary to meet the needs of all of Iowa's citizens.
2. **Replace the current institution based mandates with a defined set of core community services:** The current mandates need to be replaced with a set of services for eligible consumers with mental illness, mental retardation or a developmental disability. Driven by consumers, families and communities, an array of appropriate services will be more cost effective and reflect the needs of Iowans. Required core services would include inpatient, ICF/MR, residential services, but would also include innovative outpatient, community supports, case management, and habilitative and rehabilitative community services. Creative development of community based supports would be encouraged under this plan.
3. **Develop a community-friendly system by transitioning from the cumbersome process of legal settlement to principles of equitable service access based on residency**: Once core services are available on an equitable basis throughout Iowa, with a funding process which allows dollars to follow consumers wherever they choose to live, it will no longer be necessary to carry out the time-consuming

process of establishing legal settlement. A state payment program for individuals for whom no county of legal settlement can be established will no longer be necessary. Access to services will be based on county of residence.

4. **Increase federal funding for mental health and mental retardation services**: Iowa needs to maximize federal funding for community mental health and mental retardation / developmental disability services. Increased funding for the service system is needed, but it should come from federal funding as much as possible.

5. **Assure equity of access to core services through a funding formula in which state and county dollars are directly linked to consumers**: State funds will increase both in absolute dollars and as a proportion of total MH/DD fund dollars. Currently there is variability among Iowa Counties with regard to the amount of state and county funds available for community mental health and mental retardation/developmental disability services. This new strategy would provide equity of access through a funding formula that links state/federal dollars to actual enrolled consumers; based upon each consumer's disability and level of functioning.

6. **Expand the state-operated risk pool, and encourage counties to accrue funds to cover local risk factors**: In agreeing to these system changes, counties are assuming some financial risk. Under a true partnership, that risk should be shared by the counties and by the state. The self-insured portion of the risk, at the county level, should be defined as three months of a county's operating budget. Fund balances should be calculated in conformance with generally accepted accounting principles which allow designation of funds to maintain solvency and allow for strategic planning. The state risk pool should be expanded. Counties facing short-term financial risk because of the funding formula or unusual enrollment rates will be permitted to access the state risk pool.

7. **Redefine the roles of the state and counties in the management of mental health and mental retardation / developmental disability services and enhance the participation of consumers and families in planning, operating, and evaluating mental health and mental retardation services**: It is critical in the system restructuring plan to redefine the roles of key players in Iowa's mental health and mental retardation / developmental disability system. These partners include consumers and families, providers, advocacy groups, the State Department of Human Services, the various state mental health and developmental disability planning and oversight committees, the State-County Management Committee, and County CPC Administrators. This can be accomplished by:

   - Merging the State-County Management Committee and MH/DD Commission at the state level to provide citizen oversight of the system.
   - Redefining the role of the State Department of Human Services to emphasize its responsibilities for policy and standard setting and over-all system evaluation.
   - Redefining the roles and responsibilities of counties to emphasize their functions with regard to local system planning, development, operations, performance and quality management.
   - Establishing equity between community providers and state institutions through net budgeting.

**Conclusion:** ***Improvements through partnerships is interactive and interdependent***. In addressing issues, this proposal focuses on the system as a whole; embracing the realization that the involvement of all of Iowa's citizens is necessary for enduring improvements. This recommendation is not a quick fix, but a thoughtful long-term blueprint to begin the process of system evolution. As in any true partnership, there will be challenges. Counties will face challenges - to hold themselves accountable for administering a high quality system of services in a consistent, fair, equitable, and efficient manner. The state, as the primary funder, will be challenged to provide effective leadership through system evaluation and development of standardized practices. Thoughtful input from consumers, family members, providers and advocacy groups must guide the process. All Iowa communities will benefit greatly from this initiative if the state, counties and stakeholders work in unison to make the mental health and mental retardation / developmental disability service system a responsive, fair, and equitable process.

***(For more specific information, please refer to the Central Point of Coordination CPC Restructuring Task Force Report)***

**Objective Five: Assure equity of access to core services through a funding formula in which state and county dollars are directly linked to consumer**s: There is extreme variation among Iowa counties with regard to the amount of state and county funds available for community mental health and developmental disability services. The new strategy is intended to attain equity of service access through a funding formula that links state/federal dollars to actual enrolled consumers, based on each enrollee's disability and level of functioning.

**State Funding Formula Principles**

- State funds will increase, both in absolute dollars and as a proportion of total MH/DD Fund dollars. The proportion now averages about 50% - 50%. Over time it is intended to move to 75% state and 25% county funding. For this purpose, and consistent with SF 69, state funds are defined as being comprised of the state general fund appropriation for the mental health fund[5], plus any federal funds contributed to MH/DD, including the Social Services Block Grant (formerly Title XX), the MI/MR/DD/BI Community Services Fund, and the Federal Mental Health Block Grant.

- Initially no county would receive less than its FY2000 amount of state/federal funding to the MH/DD Fund, and no county would be required to levy more than the maximum local levy as defined by SF 69.

- As state funds are increased, they will be allocated to counties based on achieving equity of access to core services for enrolled consumers by identifying and filling gaps in the service system.

- Ultimately, when counties are delegated the authority to control and approve admission to State Hospital Schools (SHSs) and State Mental Health Institutes (MHIs), the state portion of the funding for these facilities will be included in the amount of state funds to be allotted to counties under the formula outlined below. In this way state facilities would function in the same manner as all other health care and community service providers; they would earn reimbursement based on the delivery of approved units of clinically appropriate and effective services, and on actual costs.

- Funds for the state payment program, the cost of state institution care for persons with no county of legal settlement, and the non-federal share of Medicaid funded services for persons with state case status will be allotted to the individual's county of residence, at the same rate as allotted to the county under the formula outlined below (and not at the current amount the state may be paying for each particular state payment program case.)

- State funds will be allocated based on disability-centered case rates – with each enrollee having a case rate based on disability group (MI, CMI, MR, and DD) and level of functioning. This will assure that dollars follow clients, rendering the legal settlement process unnecessary (with a few possible exceptions – see Objective 3.) Counties will receive additional funds as they enroll more consumers, and will be protected from financial risk by receiving higher rates for lower functioning individuals. If the available funding is insufficient to serve the number of newly eligible consumers in a given year, a county may have to institute waiting lists for services.

[5] Commonly referred to as Fund 10.

- In a system such as the one proposed, counties will be accepting risk for the cost of services provided, but the state will need to assume risk for an increase in the number of consumers who are eligible for services. In order to maintain the long-term solvency of the system, rate cells paid to counties will need to be adjusted annually to reflect any amounts expended from the risk pool and/or fund balances, the anticipated service costs of persons on waiting lists, and inflation.

**State Funding Formula – Operations**

- The funding formula will be based on two factors:
  - The number of clients enrolled in each county in each of four rate cells: MI, CMI, MR, and DD.
  - The average costs of service provided to individuals in each rate cell. (Note: a variety of approaches may be used to calculate this average cost per rate cell. The CPC Restructuring Task Force and the State/County Management Committee will review a number of simulations of rate calculations and recommend an approach that achieves equity of funding and service access in a timely manner, while at the same time not unduly harming any county or set of counties. In particular, the approach should ensure that counties will not be unduly harmed by the addition of state cases.) The principle is that counties will start at rate levels close to their current actual costs determined by using a standardized tool, and will move towards a statewide or regional average rate. This principle will assure that (a) counties have equitable resources with which to provide equitable access to services for enrolled consumers; and (b) allows maximum county flexibility while at the same time providing incentives for maximum cost efficiency in service delivery. Statewide or regional rates may also be adjusted for county size, location, or other naturally occurring factors.

- Each county will receive a quarterly allotment equal to the sum of average costs per rate cell times the number of individuals enrolled in each rate cell during the previous quarter. To accommodate cash flow needs of counties and reduce the level of fund balances which counties will need to maintain, the state should make payments at the beginning of each quarter based on the anticipated number of consumers, with a reconciliation to the actual number of consumers in the next quarter.

Example

**Fictitious County, Iowa**

| Rate Cell | # enrollees (annual) | Average annual cost[6] | Annual Allotment[7] |
|---|---|---|---|
| MI | 100 | $1 | $100 |
| CMI | 200 | $2 | $400 |
| MR | 300 | $3 | $900 |
| DD | 1 | $4 | $4 |
| **Total** | **601** | **NA** | **$1,404** |

[6] Rounded to nearest dollar.

[7] As noted elsewhere, the allotments are to be made on a quarterly basis. However, data provided by the state did not permit that level of analysis for the example provided here.

- Once allotted to the county, the funds become unrestricted. That is, the funds may be used for any consumer and service included in the County Management Plan. It will be up to each county to decide how to commit the funds to services on an individualized basis to specific consumers.

- While moving towards a statewide or regional case rate structure, counties will have expanded access to the risk pool (see Objective 6), to assist counties that have existing or new cost "outliers" that cannot be reasonably accommodated within the average cost structure.

- County levy funds will be blended with the state allotment, just as is now done under SF 69. As noted above, ultimately county levies will become a fixed 25% of the service costs. Thus, although county levies will be a smaller proportion of the total mental health fund, they could rise if (a) state funds increase substantially; and/or (b) substantial additional individuals enroll in the system. However, it is unlikely that a county would need to levy more than the current maximum under SF 69.

- Each county will be required to have sufficient cash on hand to cover the following: cash flow of current service expenses (3 months of service expenses so that providers can be paid before state funds are distributed to counties), funds for services which have been provided but not yet billed to the county, building maintenance and repair, investments in new programs, and a local risk pool which will cover extraordinary expenses while a county is preparing an application to the statewide risk pool. If a county accumulates more cash than allowed for the total of those line items, subsequent state payments will be reduced and the county will be required to spend those reserves.

The following factors must be considered in calculating the distribution of funds:

- Adjustments for county ability to levy based on (a) available taxable assessed valuation and (b) average per capita income;
- Adjustments to small counties for the fixed costs of administration/infrastructure;
- Core funding for crisis response/hospital diversion services, which must have base funding regardless of enrollment or utilization. Each County Management Plan will spell out how crisis/hospital diversion services will be accessed/provided on a 24/7 basis. Since many Medicaid recipients will access crisis response and hospital diversion services through the county crisis systems, the state must require its Iowa Plan contractor (Merit Behavioral Care of Iowa) to pay a fair share of the costs of these services;
- A small set-aside of funds for each county or group of counties for prevention, consultation and education, outreach, and disaster planning and response will be provided outside of the cost per enrollee[8] per rate cell methodology and fee policy as described in this document; and
- Incentives to counties for coordination, collaboration, infrastructure development, etc. (i.e., formation of regional administrative alliances, collaborative network management or infrastructure development, etc.).

[8] As used throughout this document, the term "enrollee" means an adult meeting clinical and financial eligibility
criteria who has requested and been approved for the receipt of one or more services under the County Management Plan. An enrollee is an individual for whom the county would issue a unique identifier.

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| **Measures of Success** | ➢ Attainment of the state/county funding ratio of 75%:25%.<br>➢ Standard of timely and convenient access to all core services[9] met in each county in Iowa.<br>➢ Average case rates for each rate cell decrease as counties implement service options and strategies to implement flexible, individualized lower cost services as opposed to higher cost congregate and institutional services.<br>➢ Documentation that more consumers are being enrolled and served.<br>➢ Documentation that dollars saved through county efficiency and effectiveness and re-invested by counties for new services for consumers. |

[9] To be defined in statewide performance standards.